PULMONARY CARE
OF CENTRAL FLORIDA

Sigfredo Aldarondo, MD, FCCP • Manuel Betancourt, MD, FCCP
P - 407-539-2766 F – 407-539-2786

MEDICAL RECORDS RELEASE

I, _____, hereby authorize **Pulmonary Care of Central FL, PA to:**

☐ **Release to** ☐ **Obtain from** ☐ **Release to Self (Pre-pay)**

Name: _____

Address: _____

_____

Phone: _____ **Fax:** _____

Please release the following records:

- ◘ **All Medical Records**
- ◘ **Immunization Records**
- ◘ **X-ray Results / Films / CD-Rom**
- ◘ **Laboratory Results**
- ◘ **Consultations**
- ◘ **Medically Sensitive:**

Please Initial

_____ HIV / AIDS Information / Testing
_____ Mental Health Information
_____ Substance Abuse
_____ Sexually Transmitted Disease Information
_____ Pregnancy Information
_____ Domestic Violence

- ◘ **Baseline Polysomnogram**
- ◘ **CPAP Titration PSG**
- ◘ **MSLT Results**

I understand that this consent is revocable by me, in writing, at any time except that action has been taken in reliance on it. I also understand that this consent will expire one (1) year after the date of the signature or automatically when the records requested on this form have been sent.

Name of Patient

_____DOB_____ Date: _____
Parent/Guardian (Print Name)

_____ _____
Signature Witness